

FILED MAR 22 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **10533**
2479BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				STREET ADDRESS (If rural, give location) 19 4150 Enright 21970					
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) Eugene		c. (Last) Caswell			
4. DATE OF DEATH		(Month) 3		(Day) 7		(Year) 56			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 18 1911			
9. AGE (In years last birthday) 44		IF UNDER 1 YEAR Months 9 Days 19		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Schneider Shoe Co.		11. BIRTHPLACE (City and State or Foreign Country) Marceline Missouri		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME William Caswell		13b. MOTHER'S MAIDEN NAME Missouri		14. NAME OF HUSBAND OR WIFE Ida Caswell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW # 2		17. INFORMANT'S SIGNATURE OR NAME Ida Caswell		ADDRESS 4150 Enright Ave			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH Undt.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				ANTECEDENT CAUSES DUE TO (b) Hypertension <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>					
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				Bronchopneumonia				3314	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 3-5 , 1956 , to 3-7 , 1956 , that I last saw the deceased alive on 3-7 , 1956 , and that death occurred at 2:55a m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Edw. B. Williams, M.D.				23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 3-8-56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Mar 12 1956		24c. NAME OF CEMETERY OR CREMATORY National		24d. LOCATION (City, town, or county) (State) Jefferson Brks, St. Louis Co Mo			
DATE REC'D BY LOCAL REG. MAR 9 1956		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Bell Avenue					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *S J Watson*.....

Licensed Embalmer No. *26*

P. O. Address *27690*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.